MINIMIZING RISK AVOIDANCE STRATEGIES
EXECUTIVE SUMMARY

FINDINGS

Fixed periodic per capita, or "capitated" payments by purchasers to health plans (i.e., health insurance arrangements, also known as health benefits financial intermediaries) and health plans to providers (i.e., medical groups, hospitals and other providers), if not adjusted for the medical needs of different patients, gives health plans and providers an incentive to avoid enrolling and developing expertise to care for the sickest patients.

These incentives result in "adverse selection", i.e., a competitive disadvantage for academic health centers and other providers with reputations for excellence that attract the sickest patients. Moreover, the lack of risk adjustment attenuates price competition among health plans, as plans receiving unfavorable selection are not able to compete with plans getting favorable selection on a level playing field.

Currently, health plans may use stop loss coverage, carve outs, global case rates, and other mechanisms to protect providers from financial exposure to high cost cases. In addition, what is needed to combat the problem of adverse selection is "risk adjustment", i.e., to adjust capitation payments to compensate health plans and providers for enrolling and caring for patients with more costly medical conditions, enough to eliminate incentives for skimming. According to Cardinal Bernardin, Archbishop of Chicago, "If we do not, we will witness a morally repugnant system in which plans will compete to avoid caring for the sick, thus avoiding a central purpose of healthcare altogether."

A consensus has emerged among leading experts that good enough methods are now available and ought to be put into practice.[1] For a variety of important reasons, risk adjustment should begin to be implemented as soon as possible. Because of problems of data availability, it will take several years to complete implementation.

Risk adjustment suffers from a collective action problem. In order for risk adjustment to change the incentives of a large health plan, many firms, very large firms, or some large purchasing groups need to introduce it. One employer acting on its own can not correct the incentives of unadjusted capitation. Collective action by purchasers, including the state, is needed to influence this vitally important change.

In addition, to encourage health plans to contract with the best providers and to encourage providers to develop expertise in treating the sickest patients, the adjusted payments must be passed through the health plans to their contracting medical groups, hospitals and other providers if they are capitated. Moreover, by leveling the playing field, risk adjustment can be expected to improve price competition among plans.

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[1] Joseph Newhouse, et al, "Risk Adjustment and Medicare: Taking a Closer Look", *Health Affairs*, 16:5, September/October 1997, 26-43; and Harold Luft, expert testimony to the Managed Health Care Improvement Task Force, September 23, 1997

RECOMMENDATIONS

The California Managed Health Care Improvement Task Force recognizes that risk adjustment entails some extra cost and effort in the short run, and despite that, endorses risk adjustment as worth the additional investment. We base this recommendation on the reasoned analysis that in the long run, risk adjustment will save society resources by redirecting the incentives of health plans from skimming to providing more efficient higher quality care for all patients.

Therefore, the Task Force recommends that California stimulate action, where technically feasible, to adopt risk adjustment while maintaining patient confidentiality.

1. The Task Force strongly recommends to the CalPERS Board of Administration that CalPERS, preferably in combination with the University of California and PBGH, with its nearly three million members, take the lead in introducing risk adjustment to the California market. The Task Force recommends implementation of a state-of-the-art risk adjustment system within three years. The legislature should provide $500,000 for a study of how best to implement risk adjustment and ask CalPERS to report in two years, including its progress toward risk adjustment, the cost implications, any concerns about patient privacy, and a recommendation to proceed or not to proceed and why. The Task Force believes this would be in the best interests of California public employees, and would be a great public service to the people of California.

2. The legislature or Governor should instruct the California Department of Health Services (DHS) to seek to join with the Health Care Financing Administration (HCFA, administrator of the Medicare and Medicaid programs) in a cooperative project with beneficiaries to explore expanded efforts to do risk adjustment for payments to managed care plans serving Medi-Cal beneficiaries. The legislature or Governor should require DHS to report in two years, including its progress toward risk adjustment, the cost implications, any concerns about patient privacy, and a recommendation to proceed or not to proceed and why.

3. Similarly, the legislature or Governor should instruct DHS to participate in HCFA-sponsored risk adjustment demonstration projects for managed care plans serving Medicare beneficiaries as and when such demonstration projects are proposed.

4. The legislature or Governor should direct DHS to explore with the federal Office of Personnel Management a California pilot project for risk adjustment of premiums for health plans serving federal employees in California in the Federal Employees Health Benefits Program (FEHBP).

5. Upon implementation by CalPERS of a risk adjustment mechanism, the legislature or Governor should consider requiring other new purchasing groups to risk adjust payments to participating plans within a reasonable timeframe after formation.

6. Major purchasers doing risk adjustment should require as a matter of contract, and as soon as technically feasible but no later than the year 2000, the state should require as a matter of licensure, that health plans pass through risk adjustment to their contracting providers or use some other mechanism that appropriately compensates for risk (e.g., stop loss coverage, carve outs, global case rates.

7. Major purchasers, including the state, and foundations should make moving forward the science of risk adjustment (and the ability to monitor its impact on clinical outcomes for vulnerable populations) a high priority through funding and support.

MINIMIZING RISK AVOIDANCE STRATEGIES

I. TODAY'S PROBLEM: ADVERSE SELECTION

Today, payors (i.e., employers and employer groups) almost universally pay health plans (i.e., health insurance arrangements, also known as health benefits financial intermediaries) the same premium for caring for a healthy adult and for a patient with serious, costly chronic conditions. This is true even though a seriously ill patient might cost many times as much per year to care for. Typically the same thing occurs in fixed, periodic, per capita or "capitated" payments from health plans to providers (i.e., medical groups, hospitals, and other providers), though there are some contracts in which the capitation payments are adjusted for age, sex, and less frequently severity.[2]

There is a serious problem with this practice. One might argue that the law of large numbers would cause the incidence of high cost cases among health plans to be spread evenly, so that no health plan would be likely to be injured in the competitive marketplace by unfavorable or "adverse selection" of high cost patients. This might be so if somehow patients were randomly assigned among health plans. This might also be the case if everyone purchased health insurance through their employer and all employers chose one health plan for their entire employment group, though this scenario would be undesirable because it would eliminate individual choice. However, high cost cases are definitely not spread evenly when people have choices among health plans and associated providers.

When people with chronic conditions have choices among health plans, they will naturally seek out and choose those health plans contracting with providers who are known or believed to be best at treating their costly diseases. Thus, in a competitive market, the health plans whose doctors have the best reputations for, say, treating heart disease or breast cancer or AIDS will attract the most patients with those costly conditions. Therefore, if payors pay the same amount for each enrollee, health plans will be punished with an extra cost burden for contracting with the best doctors. Or, if the one-size-fits-all capitation payments are passed through to the medical groups, the providers with the best reputations for treating costly diseases will be punished with an extra cost burden, a burden that may even threaten to drive them out of business. In this way, price competition is attenuated if plans receiving unfavorable selection are not able to compete with plans getting favorable selection on a level playing field.

In this case, a survival strategy for a medical group is to avoid developing a reputation for excellence, or (since the word is likely to get around) to avoid developing excellence itself. This is clearly an undesirable incentive. We all want a health care system that will provide the best care and technology when we or our family members become seriously ill. However, the existing standard payment methodology can work powerfully against this.

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[2] "The Physician Group Assessment of HMO Performance, 1997", Pacific Business Group on Health reports that 68.8% of HMOs adjust capitation payments to medical groups to account for differences in patients by age and gender, but only 10.3% adjust for disease severity. The survey question does not distinguish whether HMOs adjust all or only some of their payments to physician groups.

Adverse selection was a less serious problem before the era of vigorous price competition among health plans. In those times, most employers and employees behaved in a cost-unconscious manner. Typically, employers paid the entire premium, whichever plan an employee chose. In such a market, a health plan suffering unfavorable selection could always raise its rates, so was not seriously disadvantaged.

That situation is different today because increasing numbers of employers (e.g. the federal government, University of California (UC), Stanford University, and employers participating in the Pacific Business Group on Health (PBGH)) require their employees to pay the difference in premiums if they choose a more expensive plan. Given a price sensitive choice, the healthiest–those who have the least reason to care about the quality of their doctors–are likely to choose the lowest priced plans, while only the sickest are likely to be willing to pay the extra cost associated with health plans and providers that have attracted the sickest patients.

Adverse selection is an especially important issue for academic health centers (AHCs). Since they typically have deserved reputations for being among the best and most technologically advanced, they are likely to attract the sickest patients in a competitive managed care arrangement. Thus, if health plans pay unadjusted rates, AHCs will not be able to compete to provide clinical services on a level playing field. Such adverse selection is one part of the economic problem posed for AHCs by competitive managed care.

People frequently criticize health plans for employing strategies that attract healthy patients and avoid enrollment of high risk or very costly patients, commonly known as "skimming". Critics should realize that this incentive is not the creation of the health plans; it is the consequence of payors paying health plans in such a way as to create the perverse incentive to skim. That payors have behaved the way they have can be explained by a lack of understanding of the implications of the recent changes in the health care system, the lack of consensus on methods for correcting the problem, the lack of data available to improve current methods, and the lack of institutions to carry out solutions. Still, the payors must reform their payment methodology if the negative incentives are to be corrected.

II. A SOLUTION: RISK ADJUSTMENT

Perhaps the most cogent plea for risk adjustment was offered by the late Cardinal Bernardin, Archbishop of Chicago and leading spokesman of the Catholic Church in the United States on health policy. He said:

> We must develop and adopt methods to compensate health plans that enroll disproportionate numbers of sick people at the expense of plans that enroll disproportionate numbers of healthy people. *If we do not, we will witness a morally repugnant system in which plans will compete to avoid caring for the sick, thus avoiding a central purpose of healthcare altogether.* (Italics added.) These methods, known as "risk adjustment,"

> reduce incentives for managed care plans to compete based on enrolling only healthier populations.[3]

Thus it is the responsibility of purchasers, especially major purchasers with resources and market power, to reform the payment system in a way that gets the incentives right. Getting the incentives right does not mean a complete reversal from capitation. Rather, what is needed is to adjust capitation payments to compensate health plans and providers for enrolling and caring for patients with more costly medical conditions, enough to eliminate incentives for skimming.[4] By leveling the playing field, risk adjustment can be expected to improve price competition among plans.

A. Methodology

Adequately compensating health plans can be done today by "risk adjusting" premiums. In its most recent form, the risk adjustment process entails:

- gathering diagnostic information on each enrolled patient, using each health plan's computerized data base on its patients;
- using econometric methods to convert diagnostic information into expected or average cost of care per patient per year for such a patient (i.e., the enrollees' risk);
- adding up the expected costs for enrollees in each health plan and converting the totals into each plan's relative risk among competing health plans;
- adding a surcharge to the premium of each plan getting favorable selection, and using the proceeds to compensate the plans that got unfavorable selection. This step is would be performed by the sponsor or central clearing house.

Risk adjustment enables health plans getting unfavorable selection to offer a lower premium in the marketplace and therefore to be competitive with plans that got favorable selection. It is important to note that for risk adjustment to achieve its purposes, the adjusted payments must be passed through the health plans to their contracting medical groups, hospitals or other providers.

Risk adjustment improves upon reinsurance of high cost individual cases as an approach to compensate for adverse selection because (1) it is based on the expected medical needs rather than actual medical needs, and (2) it is based on the whole covered population, not just those people who become high cost cases. These characteristics of risk adjustment preserve a health plan's incentive to treat even high cost cases efficiently.

B. Adequacy of Risk Adjustment Methods

Substantial research has been conducted on risk adjustment, but there has been controversy over the adequacy of existing methods. Recently, a consensus has emerged

[3] Cardinal Bernardin, "Managing Managed Care " May 13, 1996.
[4] Joseph Newhouse, et al, "Risk Adjustment and Medicare: Taking a Closer Look", *Health Affairs*, 16:5, September/October 1997, 26-43.

among the leading experts–Professors Hal Luft and Joseph Newhouse among others–that good enough methods are now available and ought to be put into practice.[5]

So far, risk adjustment has been tried on a limited scale. From the outset of its HMO program, Medicare has used a formula that adjusts payments to HMOs based on age, sex, location, institutional and welfare status of the patients. This method has been widely criticized for not including diagnostic information. However, HCFA has begun through demonstration projects to test better risk adjustment methodologies for Medicare. Starting in 1995 with a $500,000 grant from the Robert Wood Johnson Foundation, the Health Insurance Plan of California (HIPC) with Coopers & Lybrand LLP, their consulting actuaries, introduced a risk adjustment model based on diagnostic information from hospital inpatient records, the best information available at the time.[6] The HIPC put its risk adjustment model into practical operation to very good effect in less than two years. All concerned recognize that a more comprehensive model is needed using both inpatient and outpatient information. However, the experience shows that risk adjustment is practical on a large scale.

C. Risk Adjustment Sooner Rather Than Later

There are several reasons to begin to implement risk adjustment as soon as possible. Because of problems of data availability, it will take several years to complete implementation.

- First, risk adjustment can help to correct the serious problems discussed above, that is, to get the incentives right.
- Second, risk adjustment will begin to level the playing field, in particular, by defraying the economic damage to AHCs and other providers of recognized excellence–the ones we want to be around when our family members become seriously ill.
- Third, some kinds of managed care products that offer wider access to providers naturally tend to draw unfavorable selection compared to narrow access products because the people who choose them are more likely to have health problems. Adverse selection is likely to drive these products out of the market unless there is risk adjustment to allow them to compete on a level playing field. Their demise would narrow consumer choice, weaken competition, and reduce consumer welfare.
- Fourth, risk adjustment methodology does not have to be perfect to make an impact. Arguably, some adjustment is better than no adjustment, the implementation of current risk adjustment methods will instill greater urgency among participants in the effort to improve them, such as by developing the information infrastructure required to produce outpatient data efficiently.
- Finally, and in a sense most fundamentally, risk adjustment is needed to inspire confidence in the moral integrity of the health care financing system.

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[5] Ibid.; and Harold Luft, expert testimony to the Managed Health Care Improvement Task Force, September 23, 1997

[6] Sandra Shewry, et al., "Risk Adjustment: The Missing Piece of Market Competition", *Health Affairs*, 15:1, Spring 1996, 171-181.

Progress related to risk adjustment has been slow for several reasons. For one, as explained above, the problem has emerged as a serious one only quite recently. Moreover, research producing persuasive results on methods is relatively new. Beyond these reasons, with the exception of the federal government, no individual purchaser has found introduction of risk adjustment to be beneficial because there is a collective action problem. That is, one employer acting alone cannot affect the incentives of a large health plan. For risk adjustment to be effective in addressing incentives, many firms, very large firms, or some large purchasing groups need to introduce it. In addition, for employers that offer to pay an amount related to the price of the low-priced plan, risk adjusting payments may increase the price of the low-priced plan if that plan got favorable selection, thus increasing the employer contribution even if prices overall decline. For example, under the present contribution formula, risk adjustment in CalPERS would likely cost the state several tens of millions of dollars. Employers need to adopt contribution approaches that do not tie contributions only to the low priced plan.

III. RECOMMENDATIONS

Risk adjustment entails some extra cost and effort in the short run, such as to build the requisite information infrastructure. The information, however, would be valuable for other purposes including quality management. Moreover, risk adjustment is worth the additional cost. In the long run, risk adjustment will save society resources by redirecting the incentives of health plans from skimming to providing more efficient higher quality care for all patients.

Therefore, the Task Force recommends that California stimulate action, where technically feasible, to adopt risk adjustment while maintaining patient confidentiality.

Assuming agreement that risk adjustment is a worthy goal, getting started remains a problem. In California, the two leading concentrations of commercial purchasing power rest with PBGH and CalPERS. DHS holds the analogous power on the public side. CalPERS' size, clout, competence, effectiveness as a purchaser, and unique position as public purchaser of commercial insurance, makes it the ideal candidate to lead the effort toward risk adjustment for commercial populations. The University of California has similar characteristics. PBGH as leading innovator of improved purchasing methods, to the extent it is willing and able, and DHS should also use their purchasing power to implement risk adjustment.

The following steps would bring the number of Californians under risk adjustment to some six million or more. This would likely be sufficient to change incentives. Risk adjustment would benefit the purchasers involved by saving money from unnecessary windfall payments to plans experiencing favorable selection and by making it rewarding for plans to attract the sickest patients and treat them efficiently. In addition, a risk adjustment system would enable these purchasers to price more accurately the risks being covered.

1. The Task Force strongly recommends to the CalPERS Board of Administration that CalPERS, preferably in combination with the University of California and PBGH, with its nearly three million members, take the lead in introducing risk adjustment to the California market. The Task Force recommends implementation of a state-of-the-art risk adjustment system within three years. The legislature should provide $500,000 for a study of how best to implement risk adjustment and ask CalPERS to report in two years, including its progress toward risk adjustment, the cost implications, any concerns about patient privacy, and a recommendation to proceed or not to proceed and why. The Task Force believes this would be in the best interests of California public employees, and would be a great public service to the people of California.

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7. Major purchasers, including the state, and foundations should make moving forward the science of risk adjustment (and the ability to monitor its impact on clinical outcomes for vulnerable populations) a high priority through funding and support.